DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region 10
2201 Sixth Avenue, MS/RX 43
Seattle, Washington 98121

FEB 14 2012

Bruce Goldberg, MD, Director
Oregon Health Authority
500 Summer Street Northeast, E-15
Salem, Oregon 97301-1097

RE: Oregon State Plan Amendment (SPA) Transmittal Number 10-012

Dear Dr. Goldberg:

I am pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) have approved Oregon State Plan Amendment (SPA) Transmittal Number 10-012. This SPA adds home and community-based services (HCBS) to the Medicaid State plan for individuals with chronic mental illness, under the authority of Section 1915(i) of the Social Security Act (the Act).

The SPA is approved with an effective date of January 1, 2012, and an expiration date of December 31, 2016.

Since the State has elected to target the population who can receive these Section 1915(i) State plan HCBS, CMS approves this SPA for a five-year period, in accordance with Section 1915(i)(7) of the Act. Oregon will be able to renew this SPA for an additional five-year period if CMS determines, prior to the beginning of the renewal period, that the State met federal and state requirements and that the State's monitoring is in accordance with the Quality Improvement Strategy specified in Oregon's approved SPA.

Upon publication of the final regulations for Section 1915(i) State plan HCBS, Oregon would need to come into compliance with any requirements imposed by the final regulations not already met by the State.

CMS appreciates the efforts and cooperation of the State leadership and staff throughout the review process. Please direct any questions regarding this matter to myself, or have your staff contact Wendy Hill Petras. She may be reached at either wendy.hillpetras@cms.hhs.gov or (206) 615-3814.

Sincerely,

[redacted]

Carol J.C. Peverly
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc: Judy Mohr Peterson, Administrator, Division of Medical Assistance Programs

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **10-12**

2. STATE: Oregon

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Medical Assistance

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, ~~2011~~ 2012 (P&I)

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
1915(i) of the Act

7. FEDERAL BUDGET IMPACT:
a. ~~FFY 2011 $ None (P&I)~~ **FFY 2012 $12,719,334 (P&I)**
b. ~~FFY 2012 $ -0- (P&I)~~ **FFY 2013 $30,157,978 (P&I)**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
1-39 (P&I)
~~1-40~~ **(P&I)**
Supplement 4 to Attachment 3.1-A, page ~~1-26~~ and Attachment 4.19-B, pages 12 & 13.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT: This transmittal is being submitted to add the option for Home Based Habilitation, HCBS Behavioral Habilitation, HCBS psychosocial Rehabilitation for persons with Chronic Mental Illness (CMI).

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME Judy Mohr Peterson for Bruce Goldberg, MD

14. TITLE: Administrator, DMAP Director, DHS

15. DATE SUBMITTED: 7-29-10

16. RETURN TO:
Division of Medical Assistance Programs
Department of Human Services
500 Summer Street NE E-35
Salem, OR 97301

ATTN: Jesse Anderson, State Plan Manager

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: **JULY 29 2010**

18. DATE APPROVED: FEBRUARY 14, 2012

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JANUARY 1, 2012

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
CAROL J.C. PEVERLY

22. TITLE:
ASSOCIATE REGIONAL ADMINISTRATOR, DMCHO

23. REMARKS:

Pen and Ink changes authorized by the State on 10/8/10
Pen and Ink changes authorized by the State on 12/15/2011.
Pen and Ink changes authorized by the State on 2/6/2012.
Pen and ink changes authorized by the State on 2/9/2012. (confirmed 2.13.12)

Pen & Ink changes authorized by the state on 2/14/2012

FORM HCFA-179 (07-92)

§1915(i) HCBS State plan Services
State/Territory: Oregon

Administration and Operation

The State implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for elderly and disabled individuals as set forth below.

1. **Services.** *(Specify service title(s) for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Home Based Habilitation, HCBS Behavioral Habilitation, HCBS psychosocial Rehabilitation for persons with CMI

2. **State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit.** *(Select one)*:

O	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	O	The Medical Assistance Unit *(name of unit)*:	
	●	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
		(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	Addictions and Mental Health Division (AMH)
O	The State plan HCBS benefit is operated by *(name of agency)*		
	a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

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§1915(i) HCBS State plan Services
State/Territory: Oregon

3. Distribution of State plan HCBS Operational and Administrative Functions.

☑ *(By checking this box the State assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☐	☐	☐
2 State plan HCBS enrollment managed against approved limits, if any	☐	☐	☐	☐
3 Eligibility evaluation	☑	☑	☐	☑
4 Review of participant service plans	☑	☐	☑	☐
5 Prior authorization of State plan HCBS	☑	☐	☐	☐
6 Utilization management	☑	☐	☑	☐
7 Qualified provider enrollment	☑	☐	☐	☐
8 Execution of Medicaid provider agreement	☑	☐	☐	☐
9 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☐	☐
10 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☐	☐	☐
11 Quality assurance and quality improvement activities	☑	☐	☑	☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

Medicaid Agency above is AMH

Other State Operating Agency is Seniors and People with Disabilities who determine Medicaid eligibility as a part of function #3.

Local Non-State Entity is an EQRO that makes the clinical determination that the individual meets the eligibility criteria set forth under State Plan Needs-based HCBS Eligibility Criteria.

Contracted Entity is the Mental Health Organization who perform functions #4, 6 and 11.

(By checking the following boxes the State assures that):

4. ☑ **Conflict of Interest Standards.** The State assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:
   - related by blood or marriage to the individual, or any paid caregiver of the individual
   - financially responsible for the individual
   - empowered to make financial or health-related decisions on behalf of the individual
   - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the State, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections. *(If the State chooses this option, specify the conflict of interest protections the State will implement):*

AMH assures that appropriate safeguards against conflicts of interests have been implemented in the process of eligibility determinations and independent assessments. Individuals participating in the eligibility determination will be paid staff of a external quality review organization. As such, they are independent of the financial implications of their determination.

Assessments and plans of care will be completed by staff of State Plan HCBS providers who meet the qualifications outlined as a Qualified Mental Health Professional (Graduate degree in psychology; or Bachelor's degree in nursing and be licensed by the State of Oregon; or Graduate degree in social work; or Graduate degree in a behavioral science field; or Graduate degree in recreational, art, or music therapy; or Bachelor's degree in occupational therapy and be licensed by the State of Oregon; and Education and experience which demonstrates the competencies to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social and work relationships; conduct a mental status examination;

document a multi-axial DSM diagnosis; write and supervise a treatment plan, conduct a comprehensive mental health assessment; and provide individual, family, and/or group therapy within the scope of practice. AMH values having information gained during treatment be reflected in ongoing assessments and plans of care. As a first level of oversight, Mental Health Organizations must recommend the services on the plan as medically appropriate. Because there is the appearance that a conflict of interest may exist in having the provider determine which services the individual needs to be successful, AMH has created a measurement as part of the Quality Management Strategy to ensure services requested are appropriate based on the individual's assessment.

This measure can be found on the Quality Management Strategy as Assurance 2 (Service Plan) Sub Assurance d.

5. ☑**Fair Hearings and Appeals.** The State assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

6. ☑**No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

7. ☑ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. For habilitation services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	1/2012	1/2013	3000
Year 2			
Year 3			
Year 4			
Year 5			

2. ☑**Annual Reporting.** *(By checking this box the State agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

§1915(i) HCBS State plan Services
State/Territory: Oregon

Financial Eligibility

1. ☑**Income Limits.** *(By checking this box the State assures that):* Individuals receiving State plan HCBS are in an eligibility group covered under the State's Medicaid State plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL). Individuals with incomes up to 150% of the FPL who are only eligible for Medicaid because they are receiving 1915(c) waiver services may be eligible to receive services under 1915(i) provided they meet all other requirements of the 1915(i) State plan option. The State has a process in place that identifies individuals who have income that does not exceed 150% of the FPL.

2. **Medically Needy.** *(Select one):*

●	The State does not provide State plan HCBS to the medically needy.	
O	The State provides State plan HCBS to the medically needy *(select one):*	
	O	The State elects to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy.
	O	The State does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III).

Needs-Based Evaluation/Reevaluation

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*select one*):

O	Directly by the Medicaid agency
●	By Other (*specify State agency or entity with contract with the State Medicaid agency*):
	External Quality Review Organization

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2. Qualifications of Individuals Performing Evaluation/Reevaluation. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

Qualified Mental Health Professional
Graduate degree in psychology; or
Bachelor's degree in nursing and be licensed by the State of Oregon; or
Graduate degree in social work; or
Graduate degree in a behavioral science field; or
Graduate degree in recreational, art, or music therapy; or
Bachelor's degree in occupational therapy and be licensed by the State of Oregon;
AND

Education and experience which demonstrates the competencies to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social and work relationships; conduct a mental status examination; document a multi-axial DSM diagnosis; write and supervise a treatment plan, conduct a comprehensive mental health assessment; and provide individual, family, and/or group therapy within the scope of practice.

3. Process for Performing Evaluation/Reevaluation. Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

The External Quality Review Organization (EQRO) will review the necessary clinical information (including assessment, service plan and plan of care and other relevant documentation), submitted by a staff employed by the Mental Health Organization (MHO), Local Mental Health Authority (LMHA) or their subcontractor, to make the 1915(i) eligibility determination. The Plan of Care reviewed includes an estimated number of hours of personal care assistance the individual requires.

General Medicaid financial eligibility determinations occur within 45 days; presumptive eligibility is utilized when appropriate. State Plan Needs-based HCBS Eligibility determinations will be made by the contracted certified External Quality Review Organization. This review will be conducted within the EQRO office as a paper review including a review of all necessary clinical records such as assessments and services and supports plans as necessary. The EQRO will provide a determination within 5 working days once all necessary documentation has been submitted.

4. ☑ Needs-based HCBS Eligibility Criteria. *(By checking this box the State assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

The person needs daily Assistance of at least 1 hour per day to perform at least two Personal Care Services specified in OAR 309-016-0695.

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5. ☑ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the State assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the State has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

Needs-Based/Level of Care (LOC) Criteria

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/MR (& ICF/MR LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
The person needs daily Assistance of at least 1 hour per day to perform at least two Personal Care Services specified in OAR 309-016-0695 and does not meet criteria established for 1915(c) Waiver services.	**Nursing Home Level of Care.** OAR 411-015 Priority of Paid Services. Eligibility for this level of care and the corresponding HCBS waiver requires that: *Persons have a need for assistance or full assistance in activities of daily living which are determined by a standardized assessment tool which ranks needs according to acuity on a scale of 1-18. Currently the Division is serving OSIPM eligible persons who are 18 or over and have needs at Levels 1-13. A person at Level 1 would need full assistance in 4 ADLs; mobility, eating, elimination and cognition while a person at Level 13 would only need assistance with elimination.	"Developmental disability" means a disability that originates in childhood, that is likely to continue and significantly impacts adaptive behavior as diagnosed and measured by a qualified professional. Developmental Disabilities include mental retardation, autism, cerebral palsy, epilepsy, or other neurological disabling condition that require training or support similar to that required by individuals with mental retardation, and the disability: • Originates before the individual attains the age of 22 years, except that in the case of mental retardation, the condition must be manifested before the age of 18; and	**Criteria for Long Term Psychiatric Inpatient Care** • Primary DSM Diagnosis is severe psychiatric disorder • Documented need for 24-hour hospital level medical supervision • At least one of the following conditions is met: o Need for extended (more than 21 days) regulation of Medications due to significant complications arising from severe side effects of Medications. o. Need for continued treatment with electroconvulsive therapy where an extended (more than 21 days)

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Needs-Based/Level of Care (LOC) Criteria (Cont)

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/MR (& ICF/MR LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
	• Persons who meet this criteria and who have mental illness or mental retardation or developmental disabilities are subject to an additional screening process to ensure compliance with federal PASRR standards (OAR 411-070 PASRR), *State Plan Amendment limitations* for serving persons with mental illness and to identify the best HCBS waiver for persons with MR or DD. • Individuals who are age 17 or younger and reside in a nursing facility are eligible for nursing facility services only, subject to PASRR limitations. They are not eligible to receive waivered services.	• Originates in and directly effects the brain and has continued, or can be expected to continue, indefinitely; and • Constitutes a significant impairment in adaptive behavior; and • The condition or impairment must not be primarily attributed to mental or emotional disorders, sensory impairments, substance abuse, personality disorder, learning disability or Attention Deficit Hyperactivity Disorder (ADHD). OAR 411-320-0020 or; • "Mental Retardation" defined as IQ's under 70 existing concurrently with significant impairments in adaptive behavior that are manifested during the developmental period, prior to 18 years of age.	inpatient environment is indicated and the inappropriateness of a short-term or less restrictive treatment program is documented in the Clinical Record. o Continued actual danger to self, others or property that is manifested by at least one of the following: ▪ The OHP Member has continued to make suicide attempts or substantial (life-threatening) suicidal gestures or has expressed continuous and substantial suicidal planning or substantial ongoing threats. ▪ The OHP Member has continued to show evidence of danger to others as demonstrated by continued violent acts to person or imminent plans to harm another person.

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Needs-Based/Level of Care (LOC) Criteria (Cont)

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/MR (& ICF/MR LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
		Individuals of borderline intelligence, IQ's 70-75, may be considered to have mental retardation if there is also significant impairment of adaptive behavior as diagnosed and measured by a qualified professional. The adaptive behavior must be primarily related to the issues of mental retardation. Definitions and classifications must be consistent with the "Manual of Terminology and Classification in Mental Retardation" by the American Association on Mental Deficiency, 1977 Revision. OAR 411-320-0020	▪ The OHP Member has continued to show evidence of severe inability to care for basic needs but has potential for significant improvement with treatment. ▪ Failure of intensive extended care services evidenced by documentation in the Clinical Record of: o An intensification of symptoms and/or behavior management problems beyond the capacity of the extended care service to manage within its programs; and Multiple attempts to manage symptom intensification or behavior

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Needs-Based/Level of Care (LOC) Criteria (Cont)

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/MR (& ICF/MR LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
			management problems within the local Acute Inpatient Hospital Psychiatric Care unit. • Has received all Usual and Customary Treatment including, if Medically Appropriate, establishment of a Medication program and use of a Medication Override Procedure.

*Long Term Care/Chronic Care Hospital

(By checking the following boxes the State assures that):

6. ☑ **Reevaluation Schedule**. Needs-based eligibility reevaluations are conducted at least every twelve months.

7. ☑ **Adjustment Authority**. The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

8. ☑ **Residence in home or community**. The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The State attests that each individual receiving State plan HCBS:

(i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or

(ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, if such residence meets standards for community living as defined by the State. *(If applicable, specify any residential settings, other than an individual's home or apartment, in which residents will be furnished State plan HCBS. Describe the standards for community living that optimize participant independence and community integration, promote initiative and choice in daily living, and facilitate full access to community services):*

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Individuals may receive State Plan HCBS services while residing in any community-based living situation including independent living situations, supported housing, adult foster home, residential treatment facility or home provided the individual meets the established criteria for eligibility. Individuals residing in a program licensed as a Secured Residential Treatment Facility will not be offered services under the 1915(i) Home and Community-based Services State Plan Option.

Rule requirements of Residential Treatment Facilities (6 or more people) and Homes (five or fewer people) include:

- An accessible outdoor area is required and will be made available to all residents. A portion of the accessible outdoor area will be covered and have an all weather surface, such as a patio or deck.
- Storage for a reasonable amount of resident belongings beyond that available in resident sleeping rooms will be provided;
- Privacy is offered in the residents sleeping rooms which require:
  - A limit of one or two residents;
  - A clothes closet;
  - Exterior window(s); sleeping room windows will be equipped with curtains or blinds for privacy and control of light;
  - Residents will be allowed to use their own furniture within space limitations;
- Common Use Rooms. The facility will include lounge and activity area(s) for social and recreational use, exclusively by residents, staff and invited guests;
- Kitchen
- Dining Area. A separate dining room or area where meals are served will be provided for the exclusive use of residents, employees, and invited guests
- Telephones. The facility will provide adequate access to telephones for private use by residents
- Services and activities; residents will be encouraged to care for their own needs to the extent possible. All services and activities will be provided in a manner that respects residents' rights, promotes recovery and affords personal dignity
  - Assistance and support, as necessary, to enable residents to meet personal hygiene and clothing needs;
  - Laundry services, which may include access to washer(s) and dryer(s) so residents can do their own personal laundry;
  - Activities and opportunities for socialization and recreation both within the facility and in the larger community;
  - Assistance with community navigation and transportation arrangements;

- Assistance with money management, where requested by a resident; and
- Assistance with acquiring skills to live as independently as possible;

- House Rules. The facility will develop reasonable house rules outlining operating protocols concerning, but not limited to, meal times, night-time quiet hours, guest policies and smoking. The house rules will be consistent with resident rights as delineated in OAR 309-035-0155. House rules will be posted in an area readily accessible to residents. House rules will be reviewed and updated, as necessary. Residents will be provided an opportunity to review and provide input into any proposed changes to house rules before the revisions become effective.

Additionally, the kitchen is available for use by individuals whose symptoms do not prevent them from having unrestricted access to the kitchen. Individuals may choose to prepare their own meals or snacks at a timeline of the individuals choosing unless limited by the House Rules. "Restriction to an area of the residence or restricting access to ordinarily accessible areas of the residence is not allowed, unless arranged for and agreed to on the Personal Care Plan." (OAR 309-040-0305)

Rule requirements of Adult Foster Homes (five or fewer people) include:

- "Homelike Environment" means an Adult Foster Home settings, which promotes the dignity, safety, independence, security, health and comfort of residents through the provision of personalized care and services to encourage independence, choice, and decision making of the residents;
- Outdoor Areas. An accessible outdoor area is required and will be made available to residents. A portion of the outdoor area will be covered and have an all weather surface, such as a patio or deck.
- Storage Areas. Storage for a reasonable amount of resident personal belongings beyond that of the resident sleeping room will be made available;
- Bathrooms. No person will walk through another person's bedroom to get to a bathroom and will have barrier-free access to toilet and bathing facilities with appropriate fixtures;
- Bedrooms. All resident sleeping rooms will include a minimum of 70 square feet of usable floor space for each resident or 120 square feet for two residents and have no more than two persons per room and allow for a minimum of three feet between beds. In determining maximum capacity, consideration will be given to whether children over the age of five have a bedroom separate from their parents. Each bedroom will have sufficient separate, private dresser and closet space for each resident's clothing and personal effects, including hygiene and grooming supplies. Residents will be allowed to keep and use reasonable amounts of personal belongings, and to have private, secure storage space. Drapes or shades for windows will be in good condition and allow privacy for residents;

- Common Use Rooms. There will be at least 150 square feet of common space, and sufficient comfortable furniture in the Adult Foster Home to accommodate the recreational and socialization needs of the occupants at one time. Common space will not be located in the basement or garages unless such space was constructed for that purpose or has otherwise been legalized under permit.
- Kitchen
- Telephones. A telephone will be available and accessible for residents' use for incoming and outgoing calls in the Adult Foster Home. Limitations on the use of the telephone by residents are to be specified in the written house rules. Individual restrictions must be specified in the individual residents Personal Care Plan. In all cases, a telephone will be accessible to residents for outgoing calls (emergencies) 24 hours a day
- Personal Hygiene Items. Each resident will be assisted in obtaining personal hygiene items in accordance with individual needs. These will be stored in a clean and sanitary manner, and may be purchased with the resident's personal allowance. Personal hygiene items include, but are not limited to, a comb and/or hairbrush, a toothbrush, toothpaste, menstrual supplies (if needed), towels and washcloths;
- Self-administration of medication

- Bill of rights: Residents of adult foster homes have the following rights. Providers shall guarantee these rights and help residents exercise them. The provider shall post a copy of the Residents' Bill of Rights in the entry or other equally prominent place in the adult foster home. The Residents' Bill of Rights states that each resident of an adult foster home has the right to:

(1) Be treated as an adult, with respect and dignity.
(2) Be informed of all resident rights and all house rules.
(3) Be encouraged and assisted to exercise legal rights, including the right to vote.
(4) Be informed of the resident's medical condition and the right to consent to or refuse treatment.
(5) Receive appropriate care and services, and prompt medical care as needed.
(6) A safe and secure environment.
(7) Be free from mental and physical abuse.
(8) Be free from chemical or physical restraints except as ordered by a physician or other qualified practitioner.
(9) Complete privacy when receiving treatment or personal care.
(10) Associate and communicate privately with any person the resident chooses.
(11) Send and receive personal mail unopened.
(12) Participate in activities of social, religious and community groups.

(13) Have medical and personal information kept confidential.
(14) Keep and use a reasonable amount of personal clothing and belongings, and to have a reasonable amount of private, secure storage space.
(15) Manage the resident's own money and financial affairs unless legally restricted.
(16) Be free from financial exploitation. The provider may not charge or ask for application fees or nonrefundable deposits and may not solicit, accept or receive money or property from a resident other than the amount agreed to for services.
(17) A written agreement regarding the services to be provided and the rate schedule to be charged. The provider must give 30 days' written notice before any change in the rates or the ownership of the home.
(18) Not to be transferred or moved out of the adult foster home without 30 days' advance written notice and an opportunity for a hearing. A provider may transfer or discharge a resident only for medical reasons including a medical emergency described in ORS 443.738 (11)(b), or for the welfare of the resident or other residents, or for nonpayment.
(19) Be free of discrimination in regard to race, color, religion, sex, sexual orientation or national origin.
(20) Make suggestions and complaints without fear of retaliation
Additionally, the kitchen is available for use by individuals whose symptoms do not prevent them from having unrestricted access to the kitchen. Individuals may choose to prepare their own meals or snacks at a timeline of the individuals choosing unless limited by the House Rules. "Restriction to an area of the residence or restricting access to ordinarily accessible areas of the residence is not allowed, unless arranged for and agreed to on the Personal Care Plan." (OAR 309-035-0105)

Individuals residing in adult foster homes have unrestricted access to the community and a choice of roommates when more than one individual shares the same bedroom.

(iii) Services provided to individuals residing in any residential setting that meets the definition of an Institute for Mental Disease as defined in 42CFR435.1010 shall not be eligible for Federal matching funds.

9. **Target Group(s).** The State elects to target this 1915(i) State plan HCBS benefit to a specific population. With this election, the State will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the State may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C). (*Specify target group(s)*):

Due to a chronic mental illness as defined in Oregon Revised Statute 426.495.

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Person-Centered Planning & Service Delivery

(By checking the following boxes the State assures that):

1. ☑ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment is based on:
   - An objective face-to-face assessment with a person-centered process by an agent that is independent and qualified;
   - Consultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals caring for the individual;
   - An examination of the individual's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the plan of care;
   - An examination of the individual's physical and mental health care and support needs, strengths and preferences, available service and housing options, and when unpaid caregivers will be relied upon to implement the plan of care, a caregiver assessment;
   - If the State offers individuals the option to self-direct State plan HCBS, an evaluation of the ability of the individual (with and without supports), or the individual's representative, to exercise budget and/or employer authority; and
   - A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.
2. ☑ Based on the independent assessment, the individualized plan of care:
   - Is developed with a person-centered process in consultation with the individual, and others at the option of the individual such as the individual's spouse, family, guardian, and treating and consulting health care and support professionals. The person-centered planning process must identify the individual's physical and mental health support needs, strengths and preferences, and desired outcomes;
   - Takes into account the extent of, and need for, any family or other supports for the individual, and neither duplicates, nor compels, natural supports;
   - Prevents the provision of unnecessary or inappropriate care;
   - Identifies the State plan HCBS that the individual is assessed to need;
   - Includes any State plan HCBS in which the individual has the option to self-direct the purchase or control ;
   - Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
   - Is reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances.

Person-Centered Planning is a core value in the provision of services and supports. Oregon has defined "person-directed" as "the individual, and others involved in supporting the treatment and recovery of the individual, are actively involved in assessment, planning and revising services and supports and intended outcomes. Individuals are empowered through this process to regain their health, safety and independence to the greatest extent possible and in a manner that is holistic and specific to the individual, including culturally, developmentally, age and gender appropriate." Oregon Administrative Rules require the clinical record to include documentation of collaboration between the individual and provider in the development of the services and supports plan. Individuals that meet the criteria for HCBS services are free to choose their provider from all authorized, available and willing providers. Individuals are encouraged to participate in the planning and delivery of the services and supports available to them and change providers at any time.

3. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS. *(Specify qualifications):*

Qualified Mental Health Professional (QMHP)
Qualifications for a **QMHP** are:
Graduate degree in psychology; or
Bachelor's degree in nursing and be licensed by the State of Oregon; or
Graduate degree in social work; or
Graduate degree in a behavioral science field; or
Graduate degree in recreational, art, or music therapy; or
Bachelor's degree in occupational therapy and be licensed by the State of Oregon;
AND

Education and experience which demonstrates the competencies to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social and work relationships; conduct a mental status examination; document a multi-axial DSM diagnosis; write and supervise a treatment plan, conduct a comprehensive mental health assessment; and provide individual, family, and/or group therapy within the scope of practice.

4. **Responsibility for Plan of Care Development**. There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care. *(Specify qualifications):*

Qualified Mental Health Professional (QMHP)
Qualifications for a **QMHP** are:
Graduate degree in psychology; or
Bachelor's degree in nursing and be licensed by the State of Oregon; or
Graduate degree in social work; or
Graduate degree in a behavioral science field; or
Graduate degree in recreational, art, or music therapy; or
Bachelor's degree in occupational therapy and be licensed by the State of Oregon;
AND

4. Responsibility for Plan of Care Development(Cont).

Education and experience which demonstrates the competencies to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social and work relationships; conduct a mental status examination; document a multi-axial DSM diagnosis; write and supervise a treatment plan, conduct a comprehensive mental health assessment; and provide individual, family, and/or group therapy within the scope of practice.

All services contained within the Individual Services and Supports Plans are recommended by a physician or other licensed healthcare practitioner. A licensed healthcare practitioner means a practitioner of the healing arts, acting within the scope of his or her practice under State law, who is licensed by a recognized governing board in Oregon (including but not limited to: Psychiatrist, Psychologist, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, and Licensed Professional Counselor)

5. **Supporting the Participant in Plan of Care Development**. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the plan of care development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

OAR 309-032-1530 **Individual Service and Support Planning and Coordination**

(C) Engagement and agreement of the individual, and family if applicable, in the development of the ISSP.

(d) Individuals, and family members, as applicable, must collaboratively participate in the development of the ISSP.

(e) Providers must fully inform the individual and guardian when applicable, of the proposed services and supports, in developmentally and culturally appropriate language, and give the individual and guardian when applicable, a written copy of the ISSP.

6. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the plan of care):*

Participants will be offered a choice of authorized, available and willing providers who can meet the needs and provide the individualized services identified in the participants plan of care. This process will be documented in the clinical record. The individual may work with the MHO directly without the direct involvement of the provider to identify appropriate residential options.

7. **Process for Making Plan of Care Subject to the Approval of the Medicaid Agency**. *(Describe the process by which the plan of care is made subject to the approval of the Medicaid agency):*

Providers are required to receive prior authorization for Rehabilitative Mental Health Services and Personal Care services. Prior Authorization requests and Plans of Care are submitted to AMH and all are reviewed for clinical appropriateness based on the required supporting documentation submitted along with the request. A provider can not receive reimbursement for a claim if the approved Prior Authorization or Plan of Care has not been entered into the system.

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8. **Maintenance of Plan of Care Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

☑	Medicaid agency - AMH	☐	Operating agency	☐	Case manager
☑	Other (*specify):*	Mental Health Organization			

Services

1. **State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	**Home Based Habilitation**
Service Definition (Scope): Habilitation services are designed to help the individual attain or maintain their maximal level of physical, mental, and social functioning and independence. Services are provided in order to assist an individual to acquire, retain or improve skills in the following areas: assistance with activities of daily living, cooking, home maintenance, recreation, community inclusion and mobility, money management, shopping, community survival skills, communication, self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.	
Home Based Habilitation is based on each individual assessment and individual services and support plan to deliver a combination of the following services: o Assistance w. IADL and ADLs o Staff as needed to support the individual's recovery o Assistance in obtaining Non Medical Transportation o Skill development (ADL's, cooking, home maintenance, recreation, community mobility, money management, shopping, community survival skills, educational support) and may be delivered in the community, adult foster home, residential treatment home or residential treatment facilities that are not considered secured.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Participants requiring skills development, behavioral support, activity therapy or supports for the maintenance of psychosocial skills on a 24/7 basis would be authorized to receive Home Based Habilitation from Providers who meet or have employees who meet qualifications to deliver Habilitation.	
Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*	
☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

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Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Qualified Mental Health Professional			Graduate degree in psychology; or Bachelor's degree in nursing and be licensed by the State of Oregon; or Graduate degree in social work; or Graduate degree in a behavioral science field; or Graduate degree in recreational, art, or music therapy; or Bachelor's degree in occupational therapy and be licensed by the State of Oregon; AND Education and experience which demonstrates the competencies to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social and work relationships; conduct a mental status examination; document a multi-axial DSM diagnosis; write and supervise a treatment plan, conduct a comprehensive mental health assessment; and provide individual, family, and/or group therapy within the scope of practice.
Qualified Mental Health Associate			"Qualified Mental Health Associate" or "QMHA" means a person delivering services under the direct supervision of a Qualified Mental Health Professional (QMHP) and meeting the following minimum qualifications as documented by the LMHA or designee: (a) A bachelor's degree in a behavioral sciences field; or (b) A combination of at least three year's relevant work, education, training or experience; and (c) Has the competencies necessary to: (A) Communicate effectively; (B) Understand mental health assessment, treatment and service terminology and to apply the concepts; and (C) Provide psychosocial skills development and to implement interventions prescribed on a Treatment Plan within the scope of his or her practice.

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Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Peer Services Support Specialist			An Individual who has successfully completed training through a curriculum qualified by AMH and (a) A self-identified person currently or formerly receiving mental health services; or (b) A self-identified person in recovery from a substance use disorder, who meets the abstinence requirements for recovering staff in alcohol and other drug treatment programs; or (c) A family member of an individual who is a current or former recipient of addictions or mental health services.
Recovery Assistant			(1) A qualified provider is a person who, in the judgment of the Department or its designee, can demonstrate by background, skills and abilities the capability to safely and adequately provide the services authorized. (2) A qualified provider must maintain a drug-free work place and must be approved through the criminal history check process described in OAR chapter 407, division 007. (3) A qualified provider paid by the Department must not be the parent, or step-parent of an eligible minor child, the eligible individual's spouse or another legally responsible relative.

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Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Recovery Assistant (cont)			(4) A qualified provider must be authorized to work in the United States, in accordance with U.S. Department of Homeland Security, Bureau of Citizenship and Immigration rules. (8) Criminal History Re-checks: (a) Criminal history re-checks may be conducted at the discretion of the Department or designee, in accordance with OAR chapter 407, division 007. (b) Providers must comply with criminal history re-checks by completing a new criminal history authorization form when requested to do so by the Department. The provider's failure to complete a new criminal history check authorization will result in the inactivation of the provider enrollment. Once inactivated, a provider must reapply and meet all of the standards described in this rule to have their provider enrollment reactivated. enrolled as PCA with individual provider number (9) Provider must not be included on any US Office of Inspector General Exclusion lists

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
QMHP	Local Mental Health Authority and Mental Health Organization	**Every three years**

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Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
QMHA	Local Mental Health Authority and Mental Health Organization	**Every three years**
Peer Services Support Specialist	Local Mental Health Authority and Mental Health Organization	**Every three years**
Recovery Assistant	Local Mental Health Authority and Mental Health Organization	**Every three years**
Adult Foster Home	Addictions and Mental Health Division	**Every three years**
Residential Treatment Facility/Home	Addictions and Mental Health Division	**Every two years**

Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Service Title:	**HCBS Behavioral Habilitation**

Service Definition (Scope): Services intended to improve and maintain the individual's acceptance in their residence and prevent unnecessary changes in residence

Services include
- Behavior Support
- Training and Education- Psychosocial skills
- Activity Therapy

and may be delivered in the community, adult foster home, residential treatment home or residential treatment facilities that are not considered secured.

Additional needs-based criteria for receiving the service, if applicable (specify):

Authorized via annual individualized plan of care as either;
Daily ongoing service to be provided directly by a Home Based Habilitation provider or their employees who meet the qualifications below or an;
Episodic or time limited service provided by a Qualified Provider.

Persons receiving these services would not qualify for similar services funded under section 110 of Rehabilitation Act 1973 or Individual with Disabilities Improvement Act of 2004.

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*	
☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
QMHP			Graduate degree in psychology; or Bachelor's degree in nursing and be licensed by the State of Oregon; or Graduate degree in social work; or Graduate degree in a behavioral science field; or Graduate degree in recreational, art, or music therapy; or Bachelor's degree in occupational therapy and be licensed by the State of Oregon; AND Education and experience which demonstrates the competencies to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social and work relationships; conduct a mental status examination; document a multi-axial DSM diagnosis; write and supervise a treatment plan, conduct a comprehensive mental health assessment; and provide individual, family, and/or group therapy within the scope of practice.

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Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
QMHA			"Qualified Mental Health Associate" or "QMHA" means a person delivering services under the direct supervision of a Qualified Mental Health Professional (QMHP) and meeting the following minimum qualifications as documented by the LMHA or designee: (a) A bachelor's degree in a behavioral sciences field; or (b) A combination of at least three year's relevant work, education, training or experience; and (c) Has the competencies necessary to: (A) Communicate effectively; (B) Understand mental health assessment, treatment and service terminology and to apply the concepts; and (C) Provide psychosocial skills development and to implement interventions prescribed on a Treatment Plan within the scope of his or her practice.
Peer Services Support Specialist			An Individual who has successfully completed training through a curriculum qualified by AMH and * (a) A self-identified person currently or formerly receiving mental health services; or * (b) A self-identified person in recovery from a substance use disorder, who meets the abstinence requirements for recovering staff in alcohol and other drug treatment programs; or * (c) A family member of an individual who is a current or former recipient of addictions or mental health services.

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Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Recovery Assistant			1) A qualified provider is a person who, in the judgment of the Department or its designee, can demonstrate by background, skills and abilities the capability to safely and adequately provide the services authorized. (2) A qualified provider must maintain a drug-free work place and must be approved through the criminal history check process described in OAR chapter 407, division 007. (3) A qualified provider paid by the Department must not be the parent, or step-parent of an eligible minor child, the eligible individual's spouse or another legally responsible relative. (4) A qualified provider must be authorized to work in the Unit States, in accordance with U.S. Department of Homeland Security, Bureau of Citizenship and Immigration rules. (8) Criminal History Re-checks: (a) Criminal history re-checks may be conducted at the discretion of the Department or designee, in accordance with OAR chapter 407, division 007. (b) Providers must comply with criminal history re-checks by completing a new criminal history authorization form when requested to do so by the Department.

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Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Recovery Assistant			(b) Cont- The provider's failure to complete a new criminal history check authorization will result in the inactivation of the provider enrollment. Once inactivated, a provider must reapply and meet all of the standards described in this rule to have their provider enrollment reactivated. enrolled as PCA with individual provider number (9) Provider must not be included on any US Office of Inspector General Exclusion lists
Adult Foster Home			Rule requirements of Adult Foster Homes (five or fewer people) include: • "Homelike Environment" means an Adult Foster Home settings, which promotes the dignity, safety, independence, security, health and comfort of residents through the provision of personalized care and services to encourage independence, choice, and decision making of the residents;

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Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Adult Foster Home			Outdoor Areas. An accessible outdoor area is required and will be made available to residents • A portion of the outdoor area will be covered and have an all weather surface, such as a patio or deck. • Storage Areas. Storage for a reasonable amount of resident personal belongings beyond that of the resident sleeping room will be made available; • Bathrooms. No person will walk through another person's bedroom to get to a bathroom and will have barrier-free access to toilet and bathing facilities with appropriate fixtures; • Bedrooms. All resident sleeping rooms will include a minimum of 70 square feet of usable floor space for each resident or 120 square feet for two residents and have no more than two persons per room and allow for a minimum of three feet between beds. In determining maximum capacity, consideration will be given to whether children over the age of five have a bedroom separate from their parents.

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Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Adult Foster Home			Each bedroom will have sufficient separate, private dresser and closet space for each resident's clothing and personal effects, including hygiene and grooming supplies. Residents will be allowed to keep and use reasonable amounts of personal belongings, and to have private, secure storage space. Drapes or shades for windows will be in good condition and allow privacy for residents; • Common Use Rooms. There will be at least 150 square feet of common space, and sufficient comfortable furniture in the Adult Foster Home to accommodate the recreational and socialization needs of the occupants at one time. Common space will not be located in the basement or garages unless such space was constructed for that purpose or has otherwise been legalized under permit. • Kitchen • Telephones. A telephone will be available and accessible for residents' use for incoming and outgoing calls in the Adult Foster Home. Limitations on the use of the telephone by residents are to be specified in the written house rules. Individual restrictions must be specified in the individual residents Personal Care Plan. In all cases, a telephone will be accessible to residents for outgoing calls (emergencies) 24 hours a day

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Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Adult Foster Home			• Personal Hygiene Items. Each resident will be assisted in obtaining personal hygiene items in accordance with individual needs. These will be stored in a clean and sanitary manner, and may be purchased with the resident's personal allowance. Personal hygiene items include, but are not limited to, a comb and/or hairbrush, a toothbrush, toothpaste, menstrual supplies (if needed), towels and washcloths; • Self-administration of medication • Bill of rights: Residents of adult foster homes have the following rights. Providers shall guarantee these rights and help residents exercise them. The provider shall post a copy of the Residents' Bill of Rights in the entry or other equally prominent place in the adult foster home. The Residents' Bill of Rights states that each resident of an adult foster home has the right to: (1) Be treated as an adult, with respect and dignity. (2) Be informed of all resident rights and all house rules. (3) Be encouraged and assisted to exercise legal rights, including the right to vote. (4) Be informed of the resident's medical condition and the right to consent to or refuse treatment.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Adult Foster Home			(5) Receive appropriate care and services, and prompt medical care as needed. (6) A safe and secure environment. (7) Be free from mental and physical abuse. (8) Be free from chemical or physical restraints except as ordered by a physician or other qualified practitioner. (9) Complete privacy when receiving treatment or personal care. (10) Associate and communicate privately with any person the resident chooses (11) Send and receive personal mail unopened. (12) Participate in activities of social, religious and community groups. (13) Have medical and personal information kept confidential. (14) Keep and use a reasonable amount of personal clothing and belongings, and to have a reasonable amount of private, secure storage space. (15) Manage the resident's own money and financial affairs unless legally restricted.

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Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Adult Foster Home			(16) Be free from financial exploitation. The provider may not charge or ask for application fees or nonrefundable deposits and may not solicit, accept or receive money or property from a resident other than the amount agreed to for services. (17) A written agreement regarding the services to be provided and the rate schedule to be charged. The provider must give 30 days' written notice before any change in the rates or the ownership of the home. (18) Not to be transferred or moved out of the adult foster home without 30 days' advance written notice and an opportunity for a hearing. A provider may transfer or discharge a resident only for medical reasons including a medical emergency described in ORS 443.738 (11)(b), or for the welfare of the resident or other residents, or for nonpayment. (19) Be free of discrimination in regard to race, color, religion, sex, sexual orientation or national origin. (20) Make suggestions and complaints without fear of retaliation Additionally, the kitchen is available for use by individuals whose symptoms do not prevent them from having unrestricted access to the kitchen. Individuals may choose to prepare their own meals or snacks at a timeline of the individuals choosing unless limited by the House Rules.

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Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Adult Foster Home			"Restriction to an area of the residence or restricting access to ordinarily accessible areas of the residence is not allowed, unless arranged for and agreed to on the Personal Care Plan." (OAR 309-035-0105) Individuals residing in adult foster homes have unrestricted access to the community and a choice of roommates when more than one individual shares the same bedroom.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
QMHP	Local Mental Health Authority and Mental Health Organization	**Every Three Years**
QMHA	Local Mental Health Authority and Mental Health Organization	**Every Three Years**
Adult Foster Home	Addictions and Mental Health Division	**Every Two Years**

Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover)*:	
Service Title:	**HCBS Psychosocial Rehabilitation for Persons w. CMI**
Service Definition (Scope): Rehabilitative Mental Health Services are medical or remedial services recommended by a physician or other practitioner to reduce impairment to an individual's functioning associated with the symptoms of a mental disorder or to restore functioning to the highest degree possible.	

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Treatments as listed in the AMH Medicaid Rehabilitative Service Procedure Codes and Reimbursement Rates Table include:

- Comprehensive Medication Services (LMP)
- Individual Therapy
- Group Therapy
- Family Therapy
- Psychiatric Skills Training
- Psychiatric Activity Therapy
- Behavioral health counseling therapy
- Community Psychiatric Supportive Treatment

and may be delivered in the community, adult foster home, residential treatment home or residential treatment facilities that are not considered secured.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Participants requiring skills development, behavioral support, activity therapy or supports for the maintenance of psychosocial skills on a 24/7 basis would be authorized to receive Home Based Habilitation from Providers who meet or have employees who meet qualifications to deliver Habilitation.

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
QMHP			Graduate degree in psychology; or Bachelor's degree in nursing and be licensed by the State of Oregon; or Graduate degree in social work; or Graduate degree in a behavioral science field; or Graduate degree in recreational, art, or music therapy; or Bachelor's degree in occupational therapy and be licensed by the State of Oregon; AND Education and experience which demonstrates the competencies to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social and work relationships;

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Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
QMHP (Cont)			Conduct a mental status examination; document a multi-axial DSM diagnosis; write and supervise a treatment plan, conduct a comprehensive mental health assessment; and provide individual, family, and/or group therapy within the scope of practice.
QMHA			"Qualified Mental Health Associate" or "QMHA" means a person delivering services under the direct supervision of a Qualified Mental Health Professional (QMHP) and meeting the following minimum qualifications as documented by the LMHA or designee: (a) A bachelor's degree in a behavioral sciences field; or (b) A combination of at least three year's relevant work, education, training or experience; and (c) Has the competencies necessary to: (A) Communicate effectively; (B) Understand mental health assessment, treatment and service terminology and to apply the concepts; and (C) Provide psychosocial skills development and to implement interventions prescribed on a Treatment Plan within the scope of his or her practice.

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Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Peer Services Support Specialist			An Individual who has successfully completed training through a curriculum qualified by AMH and ▪ (a) A self-identified person currently or formerly receiving mental health services; or ▪ (b) A self-identified person in recovery from a substance use disorder, who meets the abstinence requirements for recovering staff in alcohol and other drug treatment programs; or ▪ (c) A family member of an individual who is a current or former recipient of addictions or mental health services.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
QMHP,	AMH, Local Mental Health Authority, and Mental Health Organization	**Every three years**
QMHA	AMH, Local Mental Health Authority, and Mental Health Organization	**Every three years**
Peer Services Support Specialist	Local Mental Health Authority, and Mental Health Organization	**Every three years**

Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	☑	Provider managed

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2. ☑ Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians. *(By checking this box the State assures that):* There are policies pertaining to payment the State makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the State makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS ; (b) how the State ensures that the provision of services by such persons is in the best interest of the individual; (c) the State's strategies for ongoing monitoring of services provided by such persons; (d) the controls to ensure that payments are made only for services rendered; and (e) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

Using a process set in State Plan HCBS (i) Plan OARs, payments for Home Based Habilitation will be made to a relative of the participant only if they a) meet all necessary Provider Qualifications as specified in licensing and other relevant OARs b) are enrolled as a Medicaid provider and have a history of providing the Habilitation service to other HCBS waiver recipients or State Plan HCBS participants and c) there are no alternative Habilitation resources available to meet the participants needs as defined in their plan of care. Case management monitoring will be increased and ongoing attempts to provide the service in an alternative setting will be part of the participants' service plan. As always the planning process is a collaborative one including the direct opinion of the service recipient so any concerns about the service provider, relative or not, is documented and may be directly discussed with the MHO or LMHA at the individual's request.

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Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. (*Select one):*

⊙	The State does not offer opportunity for participant-direction of State plan HCBS.
O	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
O	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the State. *(Specify criteria):*

2. Description of Participant-Direction. *(Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

3. Limited Implementation of Participant-Direction. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

O	Participant direction is available in all geographic areas in which State plan HCBS are available.
O	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the State. Individuals who reside in these areas may elect self-directed service delivery options offered by the State, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the State affected by this option)*:

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

5. Financial Management. *(Select one):*

O	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
O	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐ Participant–Directed Plan of Care. *(By checking this box the State assures that):* Based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Be developed through a person-centered process that is directed by the individual participant, builds upon the individual's ability (with and without support) to engage in activities that promote community life, respects individual preferences, choices, strengths, and involves families, friends, and professionals as desired or required by the individual;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual participant;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques, including contingency plans, that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.

6. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the State facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

7. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can hire and supervise staff). *(Select one):*

O	The State does not offer opportunity for participant-employer authority.	
O	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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b. Participant–Budget Authority (individual directs a budget). (*Select one):*

O	The State does not offer opportunity for participants to direct a budget.
O	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the plan of care):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards):*

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Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates)*:

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☑	HCBS Habilitation
	Fee for Service Reimbursement Existing Codes will be paired with the modifier "HW" to identify them as State Plan HCBS services. The existing reimbursement rate for the codes will be adopted. S5136HK-HW (monthly rate) for individuals living in independent settings, S5141HK-HW (monthly rate) for Adult Foster Homes, S5140HK-HW (daily) for Residential Treatment Homes, and T2048HK-HW (daily) for Residential Treatment Facilities. AMH will periodically audit the providers to ensure the appropriateness of the rates. Rate reviews are conducted continuously and each provider will have a completed rate review at least every three years. All payments will be made retroactive based on submission of claim forms directly from OHA to the provider or to a third party administrator. The rates for individuals living in independent settings, Adult Foster Homes, Residential Treatment Homes and Residential Treatment Facilities were last updated 01/01/2012 and are applicable to services rendered on or after that date. The Rate Schedule is posted at: http://www.oregon.gov/OHA/mentalhealth/tools-providers.shtml#codes
☐	HCBS Respite Care

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For Individuals with Chronic Mental Illness, the following services:		
	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☑	HCBS Psychosocial Rehabilitation
		Fee for Service Reimbursement Existing Codes will be paired with the modifier "HW" to identify them as State Plan HCBS services. The existing reimbursement rate for the codes will be adopted. AMH will periodically audit the providers that receive daily reimbursements to ensure the appropriateness of the rates. Rate reviews are conducted continuously and each provider will have a completed rate review at least every three years. All payments will be made retroactive based on submission of claim forms directly from OHA to the provider or to a third party administrator. The rates for Psychosocial Rehabilitation were last updated 01/01/2012 and are applicable to services rendered on or after that date. The Rate Schedule is posted at http://www.oregon.gov/OHA/mentalhealth/tools-providers.shtml#codes.
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)